STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495253	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NORFOLK	1401 HALSTEAD AVENUE NORFOLK, VA 23502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/06/18 through 02/14/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaint(s) were investigated during the survey. The Life Safety Code report will follow. The census in this 120 bed facility at the time of the survey was 110. The survey sample consisted of 53 current and 3 closed records.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm	E 015		3/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/09/2018

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E 015	Continued From page 1 systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility staff failed to develop policies and procedures and emergency plans to provide for sewage and waste disposal. The findings included: During the Emergency Preparedness Review on 2/13/18 at 2:30 P.M. with the Administrator, it was noted that there were no policies and procedures for sewage and waste disposal. At that time, the Administrator confirmed that there were no policies and procedures for sewage and waste	E 015	1. An agreement was made with Spivey Rentals on the rental of portable toilets and hand wash stations. 2. All residents and staff have the potential to be affected. 3. To prevent this from reoccurring the Administrator or facility designee was educated by the Regional Director of Clinical Services on E 015 Subsistence Needs for Staff and Patients regarding requirements of the regulations.	

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E 015	Continued From page 2 disposal.	E 015	4. Quarterly, the Administrator will contact Spivey Rentals to discuss potential needs due to the season and annotate correspondence in the Emergency Preparedness Plan. Any issues noted or changes made will be discussed in the QAPI meetings for further review and recommendations. 5. March 30, 2018.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients,	E 022		3/30/18

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E 022	Continued From page 3 hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility staff failed to have Emergency Preparedness Plans which included shelter in place for volunteers. The findings included: During the Emergency Preparedness Review on 2/13/18 at 2:45 P.M. with the Administrator, it was noted that there were no policies for sheltering in place for volunteers. At that time, the Administrator confirmed that there were no policies for sheltering in place for volunteers.	E 022	1. Emergency Preparedness Plan updated to address sheltering for volunteers and actions that will be taken upon activation of the EPP and volunteers. 2. All residents, staff, and volunteers have the potential to be affected. 3. A letter will be sent to all volunteers who currently serve the facility regarding sheltering in place and the EPP with a copy of each letter sent added to the EPP. New volunteers will be notified verbally and in writing by the Administrator and Activities Director with documentation kept by the Administrator in the EPP. To prevent this from reoccurring the Administrator or facility designee was educated by the Regional Director of Clinical Services on E 022 Policies/Procedures for sheltering in place. 4. Administrator or designee will audit weekly the addition of new volunteers to ensure EPP has been reviewed with them x 3 months. The results will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		3/30/18

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E 024	Continued From page 4 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility staff failed to have documentation for the use of volunteers in the Emergency Preparedness Plans. The findings included: During the Emergency Preparedness Plans review on 2/13/18 at 2:45 P.M. with the Administrator, he stated, the facility did not have documentation for the use of volunteers in the Emergency Preparedness Plans.	E 024	1. Administrator will update EPP discussing use of volunteers and actions that will be taken upon activation of the EPP. 2. All residents, staff, and volunteers have the potential to be affected. 3. A letter addressing use of volunteers during emergencies, will be sent to all volunteers who currently serve the facility with a copy of each letter sent added to the EPP. New volunteers will be notified	

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E 024	Continued From page 5	E 024	verbally and in writing of the above by the Administrator and Activities Director with documentation kept by the Administrator in the EPP. To prevent this from reoccurring the Administrator or facility designee was educated by the Regional Director of Clinical Services on E 024 Policies/Procedures - Volunteers and Staffing in the EPP. 4. Administrator or designee will audit weekly the addition of new volunteers to ensure EPP has been reviewed with them x 3 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		3/30/18

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E 037	Continued From page 6 *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 7	E 037		

expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must

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E 037	Continued From page 8 include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility staff failed to have documentation for initial and annual staff training for Emergency	E 037	1. Administrator will document training of current staff with a memorandum stating dates of training and topics discussed	

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E 037	Continued From page 9 Preparedness. The findings included: During the Emergency Preparedness Plans review on 2/13/18 at 2:45 P.M. there was no documentation that the facility conducted emergency preparedness training. During and interview with the Administrator at that time, he stated, the facility did not have documentation for initial and annual staff training for Emergency Preparedness.	E 037	during the Emergency Preparedness Training that will be placed in each staff member's employee training file. 2. All residents and staff have the potential to be affected. 3. The facility conducted Emergency Preparedness Training February 26 through March 2, 2018 as part of a bi-annual skills fair. In-service training sheets were used to document every employee that attended the training. A memorandum will be completed and signed by the Administrator and placed in each employee training file. 4. New employees will receive EPP training during orientation and have documentation of training placed in their employee file. Administrator will audit new employee's files for training weekly x 3 months. The results will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard survey was conducted 2/6/18 through 2/14/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 120 certified bed facility was	F 000		

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F 000	Continued From page 10 111 at the time of the survey. The survey sample consisted of 56 Residents.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility document review, the facility staff failed to assess a resident for self-administration of medications for 1 of 56 residents (Resident #42) in the survey sample. The facility staff failed to assess Resident #42 for self-administration of Saline Nasal Spray Solution. The findings included: Resident #42 was originally admitted to the facility on 03/09/16. Diagnosis for Resident #42 included but are not limited to Atrial Fibrillation. The current Minimum Data Set (MDS) a quarter with an Assessment Reference Date (ARD) of 12/14/17 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. During medication pass and pour on 02/09/18 at approximately 5:06 p.m., a bottle of Saline nasal spray was located on the resident's nightstand. The surveyor asked the License Practical Nurse	F 554	1. Self-Administration of Medication Assessment completed on resident # 42. 2. 100% audit of resident's with physician orders for medications to be left at bedside to identify other residents who are at risk for this issue. Those identified will have a self-administration of medication assessment completed. 3. The Assistant Director of Nursing will in-service licensed staff on the Medication Self Administration Assessment Policy. 4. Audits of all new admissions will be performed to determine the need to complete the Medication Self Administration Assessment form weekly x 2 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	3/30/18

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F 554	Continued From page 11	F 554		

(LPN) #4 if the Saline Nasal Spray should be at resident's bedside, she replied, "Yes, there's an order for her to self-administer her nasal spray."

Review of the Physician Order Sheet and Medication Administration Record (MAR) for February 2018 starting on 1/4/18 reads: Saline Nasal Spray Solution two spray in each nostril every 4 hours for dry nasal passages. Patient may self-administer and keep at bedside.

An interview was conducted with Director of Nursing (DON) on 02/13/18 at approximately 1:15 p.m., who said the Saline Nasal Spray medication should not be at the resident's bedside. The surveyor asked if a self-administration assessment was completed on Resident #42, she replied, "I do not think so but I will check." On the same day at approximately 3:05 p.m., the DON stated, the self-administration assessment was never completed.

The facility administration was informed of the finding during a briefing on 2/13/17 at approximately 3:30 p.m. The DON stated, "Before allowing resident to self-administer medication the nurse should complete the Medication Self Administration Assessment then a return demonstration should be performed by the resident."

The facility's policy: Self Administration of Medication (Date Revised: May 2016)

Policy: The resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if the resident is both mentally and physically capable of

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F 554	Continued From page 12 self-administering medication and to keep accurate documentation of administering the medications. Procedure: -Verify physician's order in the resident's chart for self-administration of specific medications under consideration. -Complete Self-Administration of Medications Assessment form (AL 1008) with the resident. -The Interdisciplinary Team will review the assessment and will document their finds under the comment section on page 2 of the self-Administration of Medications Evaluation.	F 554		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		3/30/18

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F 582	Continued From page 13 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 1 of 56 residents (Residents #22) in the survey sample. The findings included:	F 582	1. No correction to be made for this resident. 2. 100% audit of residents discharged from the SNF to LTC services since 2/14/18 will be completed to identify other residents who may be at risk for this issue.	

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F 582	Continued From page 14 Resident #22 was admitted to the nursing facility on 9/26/17 with diagnoses that included heart failure and generalized weakness. The Minimum Data Set (MDS) assessment dated 11/29/17 was a quarterly and coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no problems in the skills needed for daily decision making. On review of the Beneficiary Notification Checklists provided by the facility it was noted that Resident #22 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN (CMS-10055) were provided. Resident #22 started a Medicare Part A stay on 11/11/17, and the last covered day of this stay was 11/29/17. Resident #22 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Only an NOMNC was issued, with verbal notification to the resident on 11/27/17. On 2/9/18 at 1:00 p.m., the facility Administrator and the social worker stated they were not aware of the issuance of a SNF ABN when Medicare Part A is discontinued by the provider. They only issued the NOMNC to the residents. No additional information was provided prior to	F 582	3. Administrator or designee will educate Social Services Director on regulations regarding issuing of ABN's. All residents using their Medicare Part A benefit will be discussed in daily PPS meeting. Days remaining, discharge plan, and potential for need for long term care services will also be discussed and entered into the ABN tracking tool. 4. Social Services Director will complete the ABN tracking tool for all Part A residents. Administrator and Social Services Director will discuss daily during the Prospective Payment System meeting. The Administrator will review and sign audit weekly x 2 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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F 582	Continued From page 15 exit.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		3/30/18

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F 584	Continued From page 16 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility staff failed to maintain the residents environment in a clean, safe and comfortable manner. During the environment inspection on 2/6/18 through 2/14/18 the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable environment. The findings included: On the Two Hundred Unit: Room 206 was observed to have a large cracked in the wall at bed A. The rubber base board was observed to be coming off at the right corner of the sink. Room 210 was observed to have a very rusty over bed light fixture. The corner wall guard next to the sink was observed to be ill repaired. The wall next to the bathroom was observed to have peeling paint. On the Three Hundred Unit: Room 301 was observed to have a hole in the wall that measured approximately one inch wide and 7 inches long at the window side of the room. Room 303 was observed to have the dresser drawers coming apart at the door side of the room.	F 584	1. The cracked wall and rubber baseboard in room 206 has been repaired. The rusty over bed light fixture, peeling paint, and wall guard next to sink in room 210 has been repaired. The hole in the wall of room 301 has been repaired. The dresser in room 303 was replaced. The tube feeding pole was cleaned immediately in room 304. The dressier in room 306 was cleaned immediately. The exit door on the 300 hall was repaired immediately. The men's bathroom shower room door handle has been repaired on the 500 hall. The electrical panel 342E was locked immediately. The non-attached sink has been removed and wall repairs will be completed by March 13, 2018. The non-operational beverage table will be removed by March 30, 2018. The indention in the plaster by the beverage table will be repaired by March 13, 2018. The rust on the door frame going into the dishwashing room will be corrected by March 13, 2018. 2. 100% audit of all rooms with residents receiving tube feeding was completed to identify any residents at risk for this issue and corrections made. 3. The Administrator has initiated facility level room renovations to correct the	

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F 584	Continued From page 17 During the initial tour on 2/6/18 at 11:10 A.M., Room 304 was observed to have Jevity 1.5 hanging on a tube feeding pole with dried tan looking substance. During an interview on 2/6/18 at 2:05 P.M. with the Unit Manager, she stated, "It looks like tube feeding. I will get housekeeping." During an interview on 2/6/18 at 2:15 P.M. the Housekeeping manager stated, "Housekeeping is responsible for cleaning the floor and also the tube feeding poles; we will take care of it right away." Room 306 was observed to have the dresser with a light brown substance on it. The exit door facing west was observed to open and the alarm sounded. The 300 Unit Manager came to cut the alarm off and stated, "sometimes the wind will blow the door open and set the alarm off." On the 500 Unit, in the men's bathroom shower room, the door handle to the restroom was observed to be loose and ill fitting. The Electrical Panel box number: 342E was observed to be unlocked. In the Dining Room, there was a non-attached hand sink observed sitting on top of two blocks of wood. In the right far corner next to the non-attached sink were missing wall moldings, measuring four inches wide by two feet long on the back and side of the non-attached sink. The dining room had a non-operational beverage table. Next to the non-operational beverage table the wall had a 2 1/2 in wide by three feet long	F 584	drywall, lighting, furniture, corner guard, door, and sink repairs. The Director of Maintenance will update the Administrator as repairs are made and will be marked off the list of needed repairs. The Director of Housekeeping will add the location of poles to the housekeeper's checklist for cleaning. Upon cleaning, the designated housekeepers will sign and date the daily cleaning list for poles cleaned. The Administrator is seeking bids for repair of identified issues in the Dining Room. 4. The Administrator will maintain an audit list of repairs that are completed as identified during the survey process. Additional issues identified during the course of the year will be addressed and annotated on the same audit spreadsheet. The Director of Housekeeping will audit rooms with the tube feeding poles daily, Monday through Friday, for cleaning x 2 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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F 584	Continued From page 18 indention in the wall plaster. The metal door molding leading to the dish washing room was observed to have rusted, corroded metal around the door frame. During an interview on 2/14/18 at 10:30 A.M. with the Administrator he stated, "some items are in there capital improvement repair plans."	F 584		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 642		3/30/18

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F 642	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation, the facility staff failed to assure that 1 of 56 residents (Resident #105) in the survey sample received a complete and accurate assessment. The findings include: Resident #105 was admitted to the facility on 08/01/17. Diagnosis for Resident #105 included but not limited to Major Depressive Disorder. Resident #105's MDS with an Assessment Reference Date of 01/24/18 coded the resident with a BIMS score of 11 out of a possible 15, indicating moderate cognitive impairment. In addition, the MDS coded Resident #105 requiring total dependence of two with transfers, dependence of one with dressing, eating and toilet use, extensive assistance of one with bed mobility, personal hygiene and bathing. In addition, under section J under (Health Conditions) asked the question, "Should Pain Assessment be Conducted" the MDS was coded yes; continued review of the MDS under section J was also marked with all dashes. An interview was conducted with MDS Coordinator on 02/13/18 at approximately 8:45 a.m., who stated, Section J under pain should have been completed and that Resident #105 was interviewable. The MDS Coordinator then stated, "The dashes indicates the MDS was not completed on or before the ARD making the MDS late and incomplete." The facility administration was informed of the	F 642	1. A new MDS assessment was completed for resident # 105 and submitted. 2. 100% audit of current residents MDS assessments completed since 2/1/18 to ensure pain assessment was completed to identify other residents who may be at risk for this issue. 3. MDS Coordinator and MDS Nurse will review Resident Assessment Instrument User's manual for instructions regarding pain interviews. MDS Coordinator and MDS Nurse will complete Point Click Care Pain Assessments on day prior to Assessment Reference Date. 4. MDS Coordinator will audit facility MDS assessments for compliance weekly x 3 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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F 642	Continued From page 20 finding during a briefing on 02/14/18 at approximately 3:30 p.m. The facility did not present any further information about the findings. CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI) 1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status. Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.	F 642		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		3/30/18

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F 655	Continued From page 21 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure the baseline care plan summary was provided for 2 residents of 56 in the survey sample (Resident #313 and Resident #365). The findings included:	F 655	1. Baseline care plan was provided to residents # 313 and # 365. 2. 100% audit of residents admitted since 2/14/18 to identify other residents at risk for this issue. 3. Social Services Director developed an Interim Care Plan Summary form to be used for all new admissions.	

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F 655	Continued From page 22 Resident #313 was admitted to the facility on 1/26/18. Diagnoses for Resident #313 included but are not limited to Asthma and Diabetes. Resident #313's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/18, coded Resident #313 with short and long term memory problems and with severely impaired cognitive skills for daily decision making. Resident #313 was totally dependent on two staff for bed mobility, transfers, dressing and personal hygiene. Resident #313 was coded with a wheel chair for mobility device. Resident #313 balance was assessed as not steady, only able to stabilize with staff assistance. The Administrator was asked how the facility documented receipt of the Resident's initial care plan summary as Resident #313's husband stated he did not recall getting a summary of a Care Plan during the initial tour. The Administrator stated on 2/12/18 at approximately 10:29 AM that the Comprehensive Person Centered Interim Care Plan was not provided to either Resident #313 or to her spouse. The Administrator stated the facility had not yet started that process. An observation of Resident #313 was made on 2/6/18 at approximately 1:39 PM. She was sitting in her wheel chair crying out, wanting to get back into bed. On 2/6/18 at approximately 1:43 PM Resident #313 was observed being put back to bed by two CNA's, #4 and #5, using a Hoyer Lift. Resident #313 was screaming prior and during the transfer. On 2/7/18 at approximately 2:22 PM, Resident	F 655	MDS Coordinator to provide in-service to all Department Heads, LPN's, and RN's to educate oh now to properly fill out form and provide to resident and/or responsible party within 48 hours of admission. 4. MDS Coordinator to audit all new admissions within 72 hours x 3 months for compliance. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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#313 was observed resting quietly in bed.

On 02/12/18 at 10:29 AM, an interview was conducted with the Administrator. he Administrator stated: "Giving the baseline care was not started until 2/12/18."

The Facility Policy and Procedure titled, "Care Plan" with a revision date of 4/6/17 documented the following:

"An "Interim" Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan is Completed." The Policy and Procedure did not document the need to inform the resident and representative of the initial plan for delivery of care and services and need to give the resident and representative a written summary of the baseline care plan.

The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.
Resident #365 was admitted to the facility on 02/05/18. Diagnosis for Resident #365 included but not limited to Methicillin Resistant Staphylococcus Aureus Infection (MRSA) and Unstageable sacral pressure ulcer wound.

The admission evaluation assessment dated 02/05/18 coded Resident #365 being alert and oriented x 3. In addition, the admission evaluation assessment coded requiring assistance of two with bed mobility, toileting, and transfers and assistance of one with bathing, dressing and

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eating.

According to the Medication Administration Record (MAR) for February 05, 2018, Resident #365 was admitted to the facility on Vibramycin 100 mg 1 capsule by mouth every 12 hours and Cipro tablet 500 mg 1 tablet by mouth every 12 hours for MRSA in wounds x 2 days.

Under the investigation for pressure ulcers, the question was asked if a baseline care was completed with 48 hours after admission and was the resident or representative given a summary of that care plan.

An interview was conducted with the Administrator on 02/12/18 at approximately 10:29 a.m., who stated, "We were not start giving the resident's a copy of the their baseline care plan summary until today." The surveyor received a copy of Resident #365 care plan that was signed and dated by the residents' representative for 02/12/18.

The Facility Policy and Procedure titled, "Baseline Care Plan" with a revision date of 11/2017 documented the following:

The facility will provide the resident and their representative with a summary of the baseline care plan that includes but not limited to:
-The initial goals of the resident.
- Summary of residents medications and dietary instructions.
-Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
-Any updated information based on the detail of the comprehensive care plan, as necessary.

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F 655	Continued From page 25 The facility administration was informed of the findings during a briefing on 02/14/18 at approximately 3:30 p.m. The facility did not present any further information about the findings.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews,	F 657	1. Care plan revised to address rehab	3/30/18

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and facility documentation review, the facility failed to revise comprehensive person centered care plans for 3 of 56 residents (Residents #87, #88 and #51 in the survey sample).

1. The facility staff failed to revise Resident #87's person centered care plan to include resident options with rehab services.

2. The facility staff failed to revise Resident #88's person centered care plan to include hospice services.

3. The facility staff failed to revise the care plan for Resident #51 to include the need for a CPAP unit.

The findings included:

1. Resident #87 was originally admitted to the nursing facility on 01/10/2018. Diagnosis for included but not limited to *Enterocolitis due to *Clostridium Difficle (C-Diff).

*Enterocolitis is an inflammation involving both the large and small intestines.

*C-Diff is a bacterium that causes diarrhea (https://medlineplus.gov/clostridiumdifficileinfections.html).

The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/17/18 coded the resident with a 14 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #87 requiring extensive assistance of one with bed mobility, transfers, dressing, toilet use,

services for resident # 87. Care plan revised to address hospice for resident #88 and care plan revised to address CPAP for resident # 51.

2. 100% audit of residents receiving rehab services, with orders for CPAP and receiving hospice services to identify other residents who may be at risk for this issue.

3. The ADON or designee will in-service the Interdisciplinary Team on updating and providing a comprehensive care plan. The facility will develop a checklist to assist in guiding care plan discussions and ensuring identified deficiencies are corrected.

4. MDS Coordinator will audit care plans weekly for updates and accuracy x 2 months and then random weekly x 3 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.

5. March 30, 2018

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personal hygiene and bathing. The resident was also coded as occasionally incontinent of urine and frequently incontinent of bowel.

Resident #87's comprehensive care plan documented at risk for infection related to (r/t) C-Diff. The goal: will maintain socialization within limits of isolation. Some of the interventions to maintain the goal included: contact precautions and educate resident/family/legal representative on the importance of compliance.

On 08/18 at approximately 11:14 a.m., an interview was conducted with Resident #87 who voiced concerns that the rehab department would not allow him to participate in the therapy gym unless he wore a brief or pull-up and that was against his will.

An interview was conducted with Occupational Therapy (OT) on 2/13/18 at approximately 11:30 a.m., who stated, "Resident #87 was on contact precautions due to C-Diff and was given the opportunity to either wear a pull up and come to the rehab gym for his therapy session or wear his own underwear and have his therapy session in his room. The resident wanted his therapy session in the gym so he wore pull ups. We did not isolate Resident #87, that why we gave him an option but at the same time we also needed to protect others residents from the potential spread of infection and that was the best plan for him and the other resident."

The review of Resident's comprehensive person centered care plan did not include that Resident #87 was given the option by therapy to either wear a pull up and come to the rehab gym for his therapy session or wear his own underwear and

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have his therapy session in his room.

On 2/14/18 at approximately 8:40 a.m., an interview was conducted with OT who stated, "I did not realize that I was expected to update the resident's care plan."

The facility administration was informed of the finding during a briefing on 02/14/18 at approximately 3:30 p.m. The facility did not present any further information about the findings.

2. Resident #88 was originally admitted to the nursing facility on 08/25/2016. Diagnosis for included but not limited to Intracerebral Hemorrhage.

The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/15/18 coded the resident with a 05 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. In addition, the MDS coded Resident #88 requiring total dependence of two with transfers, total dependence of one with bed mobility, dressing eating, toilet use, personal hygiene and bathing and always incontinent of bowel and bladder. The resident was coded for receiving *hospice services.

*Hospice is a system of family-centered care designed to assist the terminally ill person to be comfortable and to maintain a satisfactory life-style through the phase of dying (Mosby's Dictionary of Medicine, Nursing and Health Professions).

The review of Resident progress note date 10/16/17 revealed the following: Failure to thrive

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with continued decline. Patient is eligible for hospice - family has been hesitant in the past; continue supportive care.

According to facility's documentation, Resident #88 was admitted to hospice services on 10/21/17.

The review of Resident #88's comprehensive care did not include a care plan for hospice care.

An interview was conducted with the MDS Coordinator on 2/13/18 at 8:45 a.m. who stated, "I'm responsible for revising care plans but I did not revise the resident's care plan to include hospice services." The MDS Coordinator stated the facility has reached out to all hospice providers to also get their hospice care plan.

A care plan for hospice care was initiated after the surveyor requested the Resident #88's hospice care plan. The care plan revision was dated for 02/12/18 to include the following: Resident has chosen hospice care related to a terminal prognosis: end stage *Cerebrovascular Accident (CVA) and *Parkinson's disease. The goal: maintain comfort. Some of the interventions to manage goal: Administer pain/symptoms relief medications as prescribed by physician, asses for verbal and nonverbal signs and symptoms relating to pain, grimacing, guarding, crying, moaning, increase anxiety and to provide space and privacy for the family to spend with resident.

CVA is a medical emergency. Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die (https://medlineplus.gov/stroke.html).

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*Parkinson's disease is a slowly progressive degenerative neurologic disorder characterized by resting tremors, pill rolling of the fingers, a masklike facies, shuffling gait, and forward flexion of the trunk, loss of postural reflexes, and muscle rigidity and weakness (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).

The facility administration was informed of the finding during a briefing on 02/14/18 at approximately 3:30 p.m. The facility did not present any further information about the findings.
3. Resident #51 was admitted to the facility on 10/28/17. Diagnoses listed for Resident #51 included but not limited to Heart Failure, Chronic Obstructive Pulmonary Disease and Diabetes.

Resident #51's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/17 coded Resident #51 as 15 out of a possible 15, indicating no cognition impairment. The Resident required one staff person assistance for transfers, walking in room and corridor, dressing, toilet use and personal hygiene.

The Comprehensive Person Centered Care Plan with a revision date of 11/2/17 identified the resident had altered Cardiac Functioning related to pacemaker, Congestive Heart Failure and Hypertension. The goal was "Will have no cardiac complications". Interventions included the following:

Assess vital signs
Cardiac assessment as needed
Diet as ordered

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Elevate Head of Bed 30-45 degrees
Monitor edema, dyspnea, pallor or cyanosis
Monitor for changes in mental status
Monitor for signs and symptoms of heart failure
Monitor oxygen saturation
Oxygen therapy as ordered
pacemaker communicator at bedside

Resident #51's Comprehensive Person Centered Care Plan did not include use and care for her CPAP (Continuous Positive Air Pressure) unit or for her diagnosis of Chronic Obstructive Pulmonary Disease.

Resident #51's Current Physician orders included:

C-Pap at hour of bedtime
Cleanse CPAP mask with soap and water every week and as needed.
Air dry prior to use as needed for CPAP care
Cleanse CPAP tubing with soap and water every week and as needed. Allow to air dry.

On 2/7/18 at approximately 4:30 PM, Resident #51 was not in her room. Resident #51's CPAP unit was observed on her bedside table. The resident also had a nebulizer that did not have a filter in it. There was no date observed on the CPAP or nebulizer tube.

On 2/12/18 at approximately 3:00 PM, Resident #51 stated that his equipment has been cleaned.

An interview with the Director of Nursing #2 was conducted on 2/13/18 at approximately 3:45 PM. The Director of Nursing stated that she was aware the facility had issues with the CPAP devices related to the multiple gaps on the

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F 657	Continued From page 32 Treatment Administrator Record. The Director of Nursing stated that it was her expectation that the CPAP should be care planned. The facility's policy: Care Plan (Revision 4/6/17). Policy: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. Procedure: -The comprehensive care plan is reviewed and updated at least every 90 days by the interdisciplinary team. -In case of significant changes in the resident's condition, The Care Plan must be updated within seven (7) days of new full MDS. -The MDS Coordinator is to review the 24-Hour Report daily for significant changes or changes in resident's ADL status. The Care planning coordinator will add minor changes in resident's status to the existing Care Plans on daily basis. The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		3/30/18

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F 686	Continued From page 33 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and review of the facility's documentation, the facility staff failed to ensure the necessary treatment was provided to prevent infection and promote healing for 1 of 56 residents (Resident #365) in the survey sample. The facility staff failed to ensure during wound care a standard to promote healing and prevent the spread of infection. The findings included: Resident #365 was admitted to the facility on 02/05/18. Diagnosis for Resident #365 included but not limited to *Methicillin Resistant Staphylococcus Aureus Infection (MRSA) and *Unstageable sacral pressure ulcer wound. *MRSA is a bacterium that causes infections in different parts of the body. It is tougher to treat than most strains of staphylococcus aureus or staph - because it is resistant to some commonly used antibiotics. *Pressure Ulcer is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs	F 686	1. No correction to be made for this deficiency. There was no negative outcome. 2. All current and new admits with open wounds are at risk for this issue. 3. The ADON will in-service all licensed staff on the proper procedures for hand washing during wound care. 4. Audits of wound care observation will be held by Unit Managers weekly x 3 months to ensure proper hand washing techniques are being followed to prevent infection. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

*Pressure Injury - Unstageable (Obscured full-thickness skin and tissue loss)
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

The admission evaluation assessment dated 02/05/18 coded Resident #365 being alert and oriented x 3. The admission evaluation assessment coded the resident as requiring assistance of two with bed mobility, toileting, and transfers and assistance of one with bathing, dressing and eating.

A Braden Risk Assessment Report was completed on 2/5/18; resident scored eleven (11) indicating very high risk for development of pressure ulcers. Mobility is completely immobile; does not make even slight changes in body or extremity position without assistance.

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According to the Medication Administration Record (MAR) for February 05, 2018, resident was admitted to the facility on *Vibramycin 100 mg 1 capsule by mouth every 12 hours and *Cipro tablet 500 mg 1 tablet by mouth every 12 hours for MRSA in wounds x 2 days.

*Vibramycin is used to treat infections caused by bacteria including intestinal (https://medlineplus.gov/ency/article/007365.htm).

*Cipro is used to treat or prevent certain infections caused by bacteria such as infectious diarrhea (infections that cause severe diarrhea) (https://medlineplus.gov/ency/article/007365.htm).

According to the admission evaluation on 2/5/18, under wound overview indicated the following: Unstageable pressure ulcer to the sacrum measuring 7.5 cm x 6.5 cm, moderate amount of *serosanguineous drainage with wound bed appearance being black in color with yellow slough, no odor present.

*Serosanquineous is a drainage -thin and red, composed of serum and blood (Mosby's Dictionary of Medicine, Nursing and Health Professions 7th Edition).

The review of Resident #365 care plan documented the resident with actual skin breakdown to the sacrum. The goal: the sacrum will show improvement and be free of signs and symptoms of infection. Some of the interventions to manage goal included but not limited to administer treatment as ordered, assess and document the status of the area (healing vs declining), *Redistribution mattress and turn and reposition as needed.

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*Alternating low air loss mattress is comprised of individual air cells that slowly inflate and deflate under the patient. The alternating or inflation/deflating of cells allow blood flow to reach all areas of the patient's body to heal and prevent bedsores (http://www.alternatingpressuremattress.com/whatisapp.html).

The current treatment as 02/06/18 was to clean sacral wound with wound cleanser, apply *betadine soaked gauze and cover with a foam dressing daily and as needed.

*Betadine is a topical anti-infective (providone-iodine) (Mosby's Dictionary of Medicine, Nursing and Health Professions 7th Edition).

On 2/8/18 at approximately 11:30 a.m., Resident #365 was lying in bed, positioned on his left side, lying on an alternating low air loss pressure mattress. A Foley catheter was at the bedside draining clear yellow urine; the catheter anchored in place. Prior to starting wound care to the resident, the wound nurse and CNA # 2 washed their hands. The wound nurse repositioned the resident on his left side with the assistance of CNA #2. The wound nurse removed her gloves, used hand sanitizer and then donned a new pair of gloves. She then removed the foam dressing that covered the sacral wound. The nurse then placed the soiled dressing inside a red biohazard bag. The sacral wound bed was noted with eschar and yellow slough; a moderate amount of serosanquineoous drainage ran down from the sacral wound; no odor was noted.

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The LPN removed her gloves, used hand sanitizer and donned another set of gloves. She then proceeded to cleansed the sacral wound in a circular motion using wound cleanser, removed the gloves, and used hand sanitizer. The Resident started having bowel movement; the nurse used 4 x 4 gauzes to clean bowel movement two times, then placed in 4 x 4 gauze in a red bag, removed the gloves, used hand sanitizer, donned a pair of gloves, then proceeded to complete wound care. The nurse painted the sacral wound with Betadine in a circular motion, removed the gloves, applied hand sanitizer, applied skin prep around the outer edges of the sacral wound, placed Betadine gauze cover with the sacral wound, then covered with a foam dressing, removed the gloves, and washed hands for 32 seconds.

An interview was conducted with the wound nurse on 2/12/18 at approximately 11:45 a.m., who stated, "I thought I washed my hands after I cleaned resident after having a bowel movement but if I didn't wash my hands; I should have."

The facility administration was informed of the findings during a briefing on 2/14/18 at approximately 3:30 p.m. The corporate nurse stated the nurse should have washed her hands after she finished providing incontinent care of stool before finishing wound care.

The facility's policy: Pressure Ulcer Policy (Revision: 1/18/17)
Policy:
It is the policy of saber Health Care based on the comprehensive assessment of a resident; the facility must ensure that -
-A resident with pressure ulcers receives

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F 686	Continued From page 38 necessary treatment services, consistent with professional standards of practice, to promote healing, prevent infections and prevent new ulcers from developing. According to The Long-Term Care Pocket Guide for Infection Control: A Resource for Frontline Staff (2008), Section 2 Hand Hygiene, "Wash hands before and after all client or body fluid contact. Immediately wash hands and other skin surfaces that are contaminated with blood or bodily fluid. When wearing gloves, wash hands as soon as the gloves are removed. Germicidal handrubs are recommended only when you can't wash."	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		3/30/18

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F 690	Continued From page 39 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed ensure appropriate care of a catheter for 1 of 56 residents (Resident #25) in the survey sample. Resident #25's suprapubic catheter bag was observed on the floor inside its protective cover. The findings included: Resident 25 was admitted to the facility on 11/123/15. Diagnosis includes but limited to *Benign Prostatic Hyperplasia (BPH). *Benign Prostatic Hyperplasia (BPH) is a nonmalignant, non-inflammatory enlargement of the prostate, most common among men over 50 years of age (Mosby's Dictionary of Medicine, Nursing and Health Professions). The current Minimum Data Set (MDS) a comprehensive assessment with an Assessment	F 690	1. Catheter was immediately secured on bed frame, lower than bladder and off the floor. 2. All residents with a catheter are at risk for this deficiency. There were no other issues identified. 3. ADON or designee will in-service nursing staff of proper techniques for urinary catheter maintenance. 4. Unit Managers will perform bi-weekly audits of placement/positioning of catheter drainage bags x 3 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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F 690	Continued From page 40	F 690		

Reference Date (ARD) of 02/1/17, coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating cognitive impairment. In addition, the MDS coded Resident #10 with dependent of one with bathing, extensive assistance of two with bed mobility, dressing, toilet use and personal hygiene. Under section H (Bladder and Bowel) the resident was coded for the use of indwelling catheter (including *Suprapubic catheter).

*Suprapubic catheter is a urinary bladder catheter inserted through the skin about 1 inch above the symphysis pubis (Mosby's Dictionary of Medicine, Nursing and Health Professions).

The review of residents comprehensive care plan documented Resident #105 with alteration in elimination related to (r/t) suprapubic catheter, incontinent of bowel. The goal: well be free of complications r/t catheter. Some of the interventions to manage goal include: keep Foley catheter bag below the level of bladder.

The review of resident's Physician Order Sheet revealed the following orders: change anchor to catheter tubing q (every) week and as needed, change 18 French Suprapubic Catheter as needed, provide privacy cover to drainage bag, provide catheter care around SP with soap and water the pat dry, maintain catheter drainage bag below the bladder level and record Foley output every shift.

During the initial tour on 02/06/18 10:57 a.m., Resident #25's suprapubic Foley catheter was observed inside a dignity bag lying on the floor. On the same day at approximately 2:35 p.m., resident catheter remained in the dignity bag on

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F 690	Continued From page 41	F 690		

floor; cloudy urine with sediment was noted in catheter line. Again on the same day at approximately 02/06/18 4:05 p.m., the resident's Foley remained in the dignity bag position on the floor.

On 02/06/18 at 4:10 p.m., the surveyor and Certified Nursing Assistant (CNA) #1 entered Resident 25's room. The surveyor asked CNA, "Is this the correct positioning for a Foley catheter, the CNA removed the Foley bag off the floor then stated, "The catheter should be hanging on the bed frame in a drainage position and not lying on the floor."

An interview was conducted with License Practical Nurse (LPN) #1 on 02/06/18 at approximately 4:15 p.m., who stated the Foley catheter should be positioned below the bladder in a dignity bag; not on the floor.

The facility administration was informed of the finding during a briefing on 2/13/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.

The Center of Disease Control (CDC) - Guidelines for Prevention of Catheter-Associated Urinary Tract Infections

Proper Techniques for Urinary Catheter Maintenance
- Maintain unobstructed urine flow.
-Keep the catheter and collecting tube free from kinking.
-Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.

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F 695	Continued From page 42	F 695		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure adequate respiratory care for 3 of 56 residents in the survey sample (Residents #51, #7, and #84). 1. The facility staff failed to ensure a Continuous Positive Air Pressure (CPAP) device was on Resident #51 per Physician Orders, and failed to ensure Resident #51 had a filter in her nebulizer. 2. The facility staff failed to ensure a CPAP device was on Resident #7, failed to ensure the CPAP unit was cleaned per facility Policy and Procedure, and failed to ensure Resident's nebulizer filter was changed. 3. The facility staff failed to ensure CPAP device was on Resident #84. The findings included: 1. Resident #51 was admitted to the facility on 10/28/17. Diagnoses for Resident #51 included	F 695	1. All CPAP's were inspected, if filters were needed, they are obtained and replaced, all were cleaned, storage bags provided, for when not in use and orders were transcribed for weekly cleaning. Including CPAP for resident # 51, # 7, and # 84. 2. All residents with CPAP's are at risk for this deficiency. 3. ADON or designee will in-service licensed nursing staff on care of CPAP machine and provision of respiratory services utilizing CPAP and/or nebulizer. 4. Unit Managers or nursing designee will perform bi-weekly random checks to ensure placement of CPAP's at bedtime x 2 months. Unit Managers or designee will audit CPAP machines and filters for cleanliness weekly x 2 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	3/30/18

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F 695	Continued From page 43 but not limited to Heart Failure, Chronic Obstructive Pulmonary Disease and Diabetes. Resident #51's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/17 coded Resident #51 as scoring a 15 out of a possible 15, indicating no cognition impairment. The Resident required one staff person assistance for transfers, walking in room and corridor, dressing, toilet use and personal hygiene. Resident #51's Current Physician orders included: C-Pap at hour of bedtime Cleanse CPAP mask with soap and water every week and as needed. Air dry prior to use as needed for CPAP care Cleanse CPAP tubing with soap and water every week and as needed. Allow to air dry. The Comprehensive Person Centered Care Plan with a revision date of 11/2/17 identified the resident had altered Cardiac Functioning related to pacemaker, Congestive Heart Failure and Hypertension. The goal was "Will have no cardiac complications". Interventions included the following: Assess vital signs Cardiac assessment as needed Diet as ordered Elevate Head of Bed 30-45 degrees Monitor edema, dyspnea, pallor or cyanosis Monitor for changes in mental status Monitor for signs and symptoms of heart failure Monitor oxygen saturation Oxygen therapy as ordered	F 695	5. March 30, 2018	

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F 695	Continued From page 44	F 695		

pacemaker communicator at bedside

Resident #51's Comprehensive Person Centered Care Plan did not include use and care for her CPAP unit or for her diagnosis of Chronic Obstructive Pulmonary Disease.

Review of Resident #51's Treatment administration record showed that on the following dates that no staff member signed that they ensured the CPAP was on the Resident.
1/5/18
1/12/18
1/18/18

On 2/7/18 at approximately 4:30 PM, Resident #51 was not in her room. Resident #51's CPAP unit was observed on her bedside table. The resident also had a nebulizer that did not have a filter in it. There was no date observed on the CPAP or nebulizer tubings.

On 2/12/18 at approximately 3:00 PM, Resident #51 stated that his equipment has been cleaned.

On 2/9/18 at approximately 4:30 PM, an interview with Licensed Practical Nurse (LPN) #5 was conducted in Resident #51's room. LPN #5 stated that she saw the CPAP at bedside and that it was not covered. She stated that to clean the CPAP one would take it apart and clean using a sanitizing wipe. The LPN stated she did not know the nebulizer needed a filter. The LPN was asked to open the area the surveyor pointed to so that she could see there was no filter in the nebulizer unit. There was no date observed on the CPAP or nebulizer tubings.

An interview with the Director of Nursing #2 was

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F 695	Continued From page 45	F 695		

conducted on 2/13/18 at approximately 3:45 PM. The Director of Nursing stated that she was aware the facility had issues with the CPAP devices related to the multiple gaps on the Treatment Administrator Record.

2. Resident #7 was admitted to the facility on 5/8/14. Diagnoses listed for Resident #7 included but are not limited to Asthma, Cerebral Palsey, and Non-Alzheimer's Disease.

Resident #7's Quarterly MDS with an ARD of 11/13/17, coded Resident #7 as having short and long term memory problems and was coded a Zero, indicating independent with decisions regarding tasks of daily life.

In addition, Resident #7 was completely dependent on two staff for bed mobility and transfers. Resident #7 was dependent on 1 staff for toilet use, personal hygiene and bathing.

The Comprehensive Person Centered Care Plan revised on 7/7/16 identified the resident focus area "Altered Cardiac/Resp (Respiratory). Functioning r/t (related to) ...asthma." The goal was to have no cardiac complications. One intervention included CPAP (Continuous Positive Airway Pressure) as ordered at HS (hour of sleep) and Oxygen therapy as ordered.

Resident #7's Physician Orders included:

1. 2/12/18 Cleanse CPAP mask with soap and water every week and as needed. Air dry prior to use. Every day shift every Saturday for CPAP care.

2. 2/12/18 Cleanse CPAP tubing with soap and

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water every week and as needed. Air dry prior to use ever day shift every Saturday for CPAP care

3. 2/22/16 CPAP at bedtime for sleep apnea CPAP to be worn every night at bedtime

Review of Resident #7's Clinical Treatment Administration Record (TAR) showed no signature of the nurse assessing that the Resident's CPAP was on, for the following dates:

1/4/18
1/11/18
1/12/18
1/15/18
1/17/18
1/20/18
1/22/18
1/29/18

On 2/6/18 during the initial tour at approximately 10:30 AM, Resident #7 stated his CPAP mask hadn't been cleaned since he had been admitted to the Facility. The Resident stated that he changes his own nebulizer filters. There were no dates observed on the CPAP unit or the Nebulizer unit. The CPAP mask was observed and it was sticky to touch.

An interview with LPN #6 was conducted on 2/8/18 at approximately 4:54 PM, she was asked how she would clean and care for the Resident's CPAP and nebulizer. LPN #6 stated that cleaning is generally done on night shift 11 PM to 7 AM, and she stated that she has worked that shift previously. LPN #6 stated that the masks are cleaned weekly with soap and water and after cleaning the masks are to be placed in a plastic bag with a date. The LPN stated that the mask

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could be cleaned as needed at any time. When asked where the filter was on the nebulizer unit, LPN #6 stated, "I didn't know the nebulizer had a filter."

An interview with the Director of Nursing #2 was conducted on 2/13/18 at approximately 3:45 PM. The Director of Nursing stated that she was aware the facility had issues with the CPAP devices related to the multiple gaps on the Treatment Administrator Record.

3. Resident #84 was admitted to the Facility on 10/3/17. Diagnoses for Resident #84 included but were not limited to Heart Failure, Respirator Failure, Diabetes Mellitus and Obstructive Sleep Apnea.

Resident #84's Admission MDS with an ARD of 10/10/17 coded Resident #84 as scoring a 15 of 15 on the BIMS (Brief Interview for Mental Status) indicating no impairment in cognition. The Resident was dependent on 2 staff for bed mobility and transfers. Resident #84 was dependent on 1 staff for Locomotion on the Unit, Toilet Use, Personal Hygiene and Bathing. Resident #84's balance was coded at not steady, only able to stabilize with staff assistance.

Resident #84's Comprehensive Person Centered Care Plan with a revision date of 10/24/17 identified the resident required oxygen related to respiratory failure and Congestive Heart Failure. The goal was for Residents oxygen levels to be kept at desired levels per Medical Doctor orders through next review. One intervention included CPAP per Medical Doctor's orders.

Resident #84's Current Physician Orders

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included:

10/28/17 Wear CPAP every night at bedtime for Obstructive Sleep Apnea.

2/12/18 Cleanse CPAP mask with soap and water every week and as needed. Air dry prior to use every day shift every Saturday for CPAP care.

2/12/18 Cleanse CPAP tubing with soap and water every week and as needed. Air dry prior to use every day shift every Saturday for CPAP care.

Review of Resident #84's Treatment Administration Record documented that a nurse did not assess to ensure that the CPAP unit was on the resident on the following nights.

1/1/18
1/4/18
1/8/18
1/18/18

The TAR did not include a cleaning order for CPAP unit or CPAP tubing. The cleaning orders were obtained on 2/12/18.

On 2/9/18 at approximately 4:45 PM, Resident #84 was observed in her room, clean and well groomed visiting with her daughter. The daughter agreed to a meeting on Monday 2/12/18 at approximately 4:15 PM to discuss her concerns for her mother related to her complaints called into the State Agency.

An interview with the Director of Nursing #2 was conducted on 2/13/18 at approximately 3:45 PM. The Director of Nursing stated that she was

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F 695	Continued From page 49 aware the facility had issues with the CPAP devices related to the multiple gaps on the Treatment Administrator Record. During a Care Plan meeting on 2/14/18 at approximately 9 AM, the resident's Power of Attorney/daughter stated her concerns that her mother was not always getting her CPAP on at night. Resident #84 stated that once she was asleep she couldn't call for anyone to put it on as she was asleep. The Facility provided undated guidance for "Cleaning Your Mask at Home" and it documented the following: "Wash your mask excluding the Headgear Assembly in soap dissolved in lukewarm water. Do not soak for more than 10 minutes." "You should clean the air tubing weekly as described." "1. Wash the air tubing in warm water using mild detergent. Do not wash in a dishwasher or washing machine." "2. Rinse the air tubing thoroughly and allow to dry, out of direct sunlight and/or heat." The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings. This is a complaint deficiency.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		3/30/18

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F 697	Continued From page 50 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure 1 Resident (Resident #313) of 56 in the survey sample was assessed and given measures for pain control during the 4.25 hours she remained sitting in her wheel chair. The findings included: Resident #313 was admitted to the facility on 1/26/18. Diagnoses for Resident #313 included but are not limited to Asthma, Adult Failure to Thrive and Diabetes. Resident #313's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 2/2/18 coded Resident #313 with short and long term memory problems and coded Resident #313 severely impaired cognitive skills for daily decision making. The Resident was unable to answer pain presence on the Admission MDS. Staff assessment for pain included: non-verbal sounds and facial expressions. The Resident was scored a 2 for indicators of pain or possible pain, meaning pain/possible pain was observed 3 to 4 days in the last 5 days. Resident #313 was totally dependent on two staff for bed mobility, transfers, dressing and personal hygiene. Resident #313 was coded with a wheel chair for mobility device. Resident #313 balance was assessed as not steady, only able to stabilize	F 697	1. Resident # 313 was transferred back to bed, positioned and as needed pain medication administered. 2. All residents are at risk for this deficiency. 3. ADON or designee will in-service licensed nurses on pain management to include pain scale, interventions, and timeliness of pain medication administration. 4. Unit Managers or nursing designee will audit ten residents weekly x 4 weeks and monthly x 2 months to monitor pain medication effectiveness. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 4. March 30, 2018	

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with staff assistance.

The Comprehensive Person Centered Interim Care Plan last revised on 2/7/18 did not include pain as a focus area.

Resident #313's Physician orders included the following medications for pain:

2/9/18 Fentanyl Patch 72 hours 12 micrograms per hour; Apply 1 application transdermally one time a day every 3 days for pain and remove as scheduled.

2/1/18 Prednisone Tablet give 10 milligrams via PEG-Tube one time a day for antiinflamatory

1/29/18 Document Pain every shift

1/27/18 Acetaminophen Tablet, Give 650 milligrams by mouth every 6 hours as needed for pain

The February Medication Administration record documented the following:

For a Pain level of 10 of 10 Acetaminophen 650 milligrams was given on 2/2/18 and documented as effective.

The Medication Administrator Record documented pain as followed:

2/1/18 Day Shift 2 of possible 10 pain scale
2/6/18 Day Shift 0 of possible 10 pain scale
2/7/18 Day Shift 6 of possible 10 pain scale

2/1/18 Evening Shift 2 of possible 10 pain scale
2/2/18 Evening Shift 10 of possible 10 pain scale

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2/6/18 Evening Shift 4 of possible 10 pain scale
2/7/18 Evening Shift 5 of possible 10 pain scale

Night Shift pain was assessed 0 of possible 10 pain scale

During February 1 through February 8, 2018 at 18:19 (6:19 PM) when the Medication Administration Record was printed, Resident #313 only received the as needed Acetaminophen as needed medication once on 2/2/18.

An observation of Resident #313 was made on 2/6/18 at approximately 1:00 PM. She was in her room, sitting in her wheel chair, calling out to her husband to get someone to put her back to bed. The husband was heard as saying I've already asked for help.

An observation of Resident #313 was made on 2/6/18 at approximately 1:39 PM. She was sitting in her wheel chair crying out, wanting to get back into bed. Resident #313 was heard stating, "I'm hurting so bad, please put me back to bed."

On 2/6/18 at approximately 1:43 PM Resident #313 was observed being put back to bed by two CNAs, #4 and #5, using a Hoyer Lift. Resident #313 was screaming prior and during the transfer. CNA #4 stated that she got Resident #313 up at 9:30 AM for Physical Therapy. CNA #4 stated she did not get Resident back in bed after Physical Therapy as she wanted her to stay up for lunch. When both CNA #4 and CNA #5 were asked if they thought that 4.25 hours was a little long to keep a Resident sitting in a wheel chair that could not position herself, they both answered, "I guess so." The Resident's husband

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stated, "I have to often wait a long time for help after ringing the bell."

An undated document was provided taken from Clinical Core System Section 100- Clinical Core Programs Pain Management and Pain Protocol, with a note documenting no policy for use of non-pharmacological measures. The document included the following:

"Positioning - Assists the resident to stay in comfortable positions
Helps with pain management
Decreases risk of complications such as pressure ulcers
Helps maintain range of motion
...
For positioning in a chair and when able to follow directions have the resident pretend to "write" the letters of the alphabet in the air using their feet then their arms. Can alternate arms and feet writing six letters at a time.

Referring a Resident to Restorative for positioning to alleviate pain is an excellent resource. It should be noted in the Restorative notes the Goal for this Program is to assist with pain relief."

The Eighth Edition of Fundamentals of Nursing Potter and Perry 2013 documented the following:

"Relieving Pain and Suffering
Relieving pain and suffering is more than giving pain medications, repositioning the patient, or cleaning a wound. The relief of pain and suffering encompasses caring nursing actions that give a patient comfort, dignity, respect, and peace. Ensuring that the patient care environment is

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F 697	Continued From page 54 clean and pleasant and includes personal items makes the physical environment a place that soothes and heals the mind, body, and spirit." "Through skillful and accurate assessment of a patient's level and type of pain you are able to design patient-centered care to improve the patient's level of comfort. There are multiple interventions for pain relief, but knowing about the patient and the meaning of his or her pain guides your care. Often conveying a quiet caring presence, touching a patient, or listening helps you to assess and understand the meaning of your patient's pain or discomfort. The caring presence helps you and your patient design goals for pain relief." "Human suffering is multifaceted, affecting a patient physically, emotionally, socially, and spiritually. It also affects the patient's family and friends. ..." The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		3/30/18

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F 761	Continued From page 55 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility documentation review, the facility staff failed to ensure one medication cart for 1 of 2 units (Unit 1) was stored in a secured location, accessible to designated staff only. The facility staff failed to ensure medication cart containing medication in the hallway was locked when not in direct sight of the nurse. The findings include: During the initial tour of the facility on 2/6/18 at approximately 9:10 a.m., the medication cart on the front hall was observed unlocked when not in direct view of the nurse. Residents were observed walking past the cart. On the same day at approximately 9:15 a.m., an interview was conducted with the Director of Nursing (DON) who stated, "The nurse should have ensured the	F 761	1. Medication cart was immediately locked. 2. All residents are at risk for this deficiency. There were no other issues identified regarding this deficiency. 3. ADON or nursing designee will in-service licensed staff on proper medication storage. 4. Random bi-weekly audits of medication carts by the Unit Managers or nursing designee will be done monthly x 3 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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medication cart was secure before she left her cart."

An interview was conducted with License Practical Nurse (LPN) #1 on 2/6/18 at approximately 9:20 a.m., who stated, "I thought I had locked my medication cart; I went to get a name badge so the surveyors could identify me." The surveyor asked the unit manager if the medication cart should be locked when not in direct view, she replied, "Yes, I should have made sure my medication cart was locked before I walked away."

On 2/9/18 at approximately 4:10 p.m., the medication cart located next to shower room was observed unlocked and unsupervised. On the same day at 4:13 p.m., the unit manger locked the medication cart and stated, "The nurse should have made sure her cart was secure before she walked away." On the same day at 4:15 p.m., an interview was conducted with LPN #5 who stated, "I was putting away medications; the medication cart is supposed to be locked."

The facility administration was informed of the finding during a briefing on 02/15/18 at approximately 3:30 p.m. The facility did not present any further information about the findings.

The facility's policy: Medications - 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles (Last revision Date: 10/31/16).

Applicability: This Policy 5.3 sets for the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles.

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F 761	Continued From page 57 General Storage Procedures: -Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, in the facility staff failed to ensure foods were stored and prepared in a sanitary manner. The findings included:	F 812	1. The open French dressing with drips down the side was disposed of immediately. The staff water bottle was removed immediately. The can opener with sticky substance was washed immediately. The spray bottle with bleach was removed from the kitchen and placed	3/30/18

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F 812	Continued From page 58 During the initial kitchen tour on 2/6/18 at approximately 10:30 AM, the following were observed: 1 opened French dressing with dressing dripping down the sides with no open date 1 staff water stored in the main Kitchen Refrigerator 1 can opener with sticky black substance on the blade 1 spray bottle of bleach sitting in the main kitchen area on top of the handwashing sink trash can On 2/14/18 at approximately 11:15 AM, an observation was made of the steam table base. Food particles of 1 small orange square looking like a piece of carrot and some beige substances floating in the water under the steam trays. A Dietary Staff member # was asked when the steam tray table was cleaned and he stated, it was cleaned at the end of the day. When asked what the items were floating in the water he stated, the orange item was a carrot from the previous day's meal. Then asked, if it is a carrot from yesterdays meal, was it cleaned at the end of the day? The Dietary Staff #4 stated, "It doesn't look like it" and further mentioned that he had not been working for a while and had just returned. The Dietary Manager #4 stated, "We don't have a refrigerator for staff only in the kitchen." When asked if the dripping French Dressing should be stored as such, the Dietary Manager stated, "No."	F 812	in the chemical room. The water under the steam tray was replaced. 2. All residents are at risk for this deficiency. 3. The Kitchen Supervisor will conduct an in-service with dietary staff about the proper procedures for labeling and dating food items, dress attire, proper hand washing, glove use, customer service, and general daily operations. 4. The Director of Dining Services will be performing weekly checks of the dry storage area, reach-in refrigerator, walk-in refrigerator, and walk-in freezer randomly throughout the week x 2 months. The Kitchen Supervisor will perform daily checks x 2 months. Results will be shared and discussed with the QAPI committee. 5. March 30, 2018	

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The Facility Policy and Procedure titled, "Infection Control" with an effective date of May 2015 documented the following:

"Purpose: To protect residents and staff by preventing the spread of infection."

"Food items to be stored shall be properly covered and marked with the date stored. Expiration dates will be monitored closely."

A document provided by the Facility dated June 12, 2009 from the CMS (Center Medicare/Medicaid Services) Pub. 100-07 State Operations Provider Certification Transmittal 48 documented the following:

"Food handling risks associated with food stored on the units may include but are not limited to: Food stored in a manner ...spillage from one food item onto another, etc.) that allows cross-contamination:..."

A document titled, "Cleaning Can Opener", provided by the Facility from a revised 2001 Operational Procedures MED-PASS, Inc documented the following:

"IMMEDIATELY AFTER USE:
1. Remove stand from base.
2. Wash blade with a brush in pot and pan sink.
3. Rinse in sanitizer. Let air dry.
4. Wash base thoroughly with brush and hot detergent water. Be sure to remove all food particles from blade and base.
5. Reassemble blade to can opener.
6. Repeat this procedure after each meal."

A titled, "Cleaning Hot Food Table" provided by

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F 812	Continued From page 60 the Facility from a revised 2001 Operational Procedures MED-PASS, Inc documented the following: "IMMEDIATELY AFTER USE:" "Interior: 1. Unplug steam table. 2. Remove all pans from steam table. 3. Mix (2) gallons water with small amount of detergent and wash thoroughly. 4. Using soap pads, scrub inside of each well. 5. Prince well with water." The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		3/30/18

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F 842	Continued From page 61 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 62 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure complete documentation for Medication Administration Records for 3 Residents out of 56 in the survey sample (Resident #58, Resident #67, and Resident #8). The findings included: 1. Resident #58 was readmitted to the facility on 1/3/16. Diagnoses included but were not limited to Diabetes, Right Below the Knee Amputation, Non-Alzheimer's Disease and Seizure disorder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/17 coded Resident #58 as scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating no cognitive impairment. The Resident required supervision with 1 staff assistance for bed mobility, transfer, locomotion on and off the Unit, and personal hygiene. The Resident required Extensive Assistance with one staff for toilet use and bathing. The Comprehensive Person Centered Care Plan with a revision date of 4/20/17 identified the	F 842	1. No correction to be made for residents # 58, # 67, and # 8. 2. All residents are at risk for this deficiency. 3. ADON or nursing designee will in-service licensed staff on the medication administration policy complete an accurate documentation. 4. Unit Managers or nursing designee will perform bi-weekly audits of MAR's and TAR's to ensure all medication/treatment administration documentation has been completed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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resident was at risk for further falls due to weakness and Left Below Knee Amputation, use of hypnotics, and diagnosis of seizure disorder. The goal was that the Resident would not sustain injury due to a fall through next review. One intervention included "medication as ordered".

Review of Resident #58's Clinical Record's January 2018 Medication Administration Record (MAR) showed the following nurse signature omissions for the following medications:

8/12/17 Physician Prescribed: Ambien Tablet 5 milligrams Give 1 tablet by mouth at bedtime for insomnia.
Omitted Nurse Signatures for the following dates:
1/11/18
1/17/18
1/22/18

2/17/16 Physician Prescribed: Atorvastatin Calcium Tablet 80 milligrams Give 80 milligrams by mouth at bedtime for hyperlipidemia.
Omitted Nurse Signatures for the following dates:
1/11/18 21:00 (9 PM)
1/17/18 21:00 (9 PM)
1/22/18 21:00 (9 PM)

5/12/17 Physician Prescribed: Levemir Solution 100 Unit/milliliter Insulin Detemir Inject 20 Units subcutaneously at bedtime for Diabetes Mellitus type II.
Omitted Nurse Signatures for the following dates:
1/11/18 21:00 (9 PM)
1/17/18 21:00 (9 PM)
1/22/18 21:00 (9 PM)

8/3/16 Physician Prescribed: Prilosec over the counter Tablet delayed Release 20 milligrams

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Give 1 tablet by mouth at bedtime for Gastro Esophageal Reflux Disease
Omitted Nurse Signatures for the following dates:
1/11/18 21:00 (9 PM)
1/17/18 21:00 (9 PM)
1/22/18 21:00 (9 PM)

2/18/16 Physician Prescribed: Cyclobenzaprine HCl Tablet 10 milligrams Give 10 milligrams by mouth two times a day for Muscle Spasm
Omitted Nurse Signatures for the following dates:
1/11/18 16:00 (4 PM)

2/17/16 Physician Prescribed: Keppra Tablet 500 milligrams Give 500 milligrams by mouth every 12 hours for Seizure Disorder
Omitted Nurse Signatures for the following dates:
1/11/18 21:00 (9 PM)
1/17/18 21:00 (9 PM)
1/22/18 21:00 (9 PM)

2/18/16 Physician Prescribed: Lyrica Capsule 25 milligrams Give 25 milligrams by mouth two times a day for Diabetic Neuropathy
Omitted Nurse Signatures for the following dates:
1/11/18 16:00 (4 PM)

5/12/17 Physician Prescribed: Metformin HCl Tablet 500 milligrams give 1 tablet by mouth two times a day for Diabetes Mellitus type II.
Omitted Nurse Signatures for the following dates:
1/11/18 16:00 (9 PM)

The Resident's Pain scale was not documented on the Evening shift on the following dates:
1/11/18
1/17/18
1/22/18

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F 842	Continued From page 65	F 842		

5/12/16 Physician Prescribed Gagapentin Capsule 100 milligrams Give 100 milligrams by mouth three times a day for Diabetes Mellitus Type II
Omitted Nurse Signatures for the following dates:
1/11/18 22:00 (10 PM)
1/17/18 22:00 (10 PM)
1/22/18 22:00 (10 PM)

2/17/16 Physician Prescribed Hydralazine HCl Tablet 100 milligrams Give 100 milligrams by mouth three times a day for Hypertension and Blood Pressure assessment
Omitted Nurse Signatures for the following dates:
1/11/18 22:00 (10 PM)
1/14/18 06:00 (6 AM)
1/17/18 22:00 (10 PM)
1/22/18 22:00 (10 PM)

12/7/16 Physician Prescribed Novolog 100 Unit/1 milliter inject as per sliding scale
Omitted Nurse Signatures for the following dates:
1/11/18 16:00 (4 PM)
1/11/18 20:00 (8 PM)
1/14/18 06:00 (6 AM)
1/17/18 16:00 (4 PM)
1/17/18 20:00 (8 PM)

The Director of Nursing stated on 2/14/18 at approximately 12:45 PM that due to the trend of dates, she had spoken with the nurse involved and stated the omissions were a documentation issue and not the Resident missing the medications.

The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not

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F 842	Continued From page 66	F 842		

present any further information about the findings.

2. Resident #67 was readmitted to the facility on 1/17/17. Diagnoses included but were not limited to Non-Alzheimer's Dementia.

The Quarterly MDS with an ARD of 1/2/18 coded Resident #67 as scoring a 6 out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating severe cognitive impairment. The resident was dependent on 1 staff for bed mobility, transfers, dressing, toilet use, bathing and personal hygiene.

The Comprehensive Person Centered Care Plan last revised 7/20/17 documented no focus areas with an intervention of give medications as ordered.

Review of the Resident's Clinical Record January 2018 Medication Administration Record showed the following nurse signature omissions for the following medications:

5/16/16 Physician Prescribed Oyster shell Calcium D Tablet 500-200 milligram-Unit Give 1 tablet by mouth four times a day for supplement
Omitted Nurse Signatures for the following dates:
1/11/18 16:00 (4 PM)
1/11/18 21:00 (9 PM)
1/15/18 16:00 (4 PM)
1/15/18 21:00 (9 PM)
1/17/18 21:00 (9 PM)
1/20/18 16:00 (4 PM)
1/20/18 21:00 (9 PM)
1/22/18 16:00 (4 PM)
1/22/18 21:00 (9 PM)

8/3/17 Physician Prescribed Reglan Tablet 10

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F 842	Continued From page 67	F 842		

milligrams Give 1 Tablet by mouth before meals and at bedtime for indigestion
Omitted Nurse Signatures for the following dates:
1/11/18 17:00 (5 PM)
1/11/18 21:00 (9 PM)
1/15/18 17:00 (5 PM)
1/15/18 21:00 (9 PM)
1/17/18 21:00 (9 PM)
1/20/18 17:00 (5 PM)
1/20/18 21:00 (9 PM)
1/22/18 17:00 (5 PM)
1/22/18 21:00 (9 PM)

The Nurse did not document Check Placement for Wanderguard on the following Evening Shift dates:
1/11/18
1/15/18
1/20/18
1/22/18

The Resident's pain scale was not documented on Evening Shift on the following dates:
1/11/18
1/15/18
1/20/18
1/22/18

8/29/17 Physician prescribed Zofran Tablet 4 milligrams Give 1 tablet by mouth at bedtime for nausea/vomiting
Omitted Nurse signatures for the following dates at 21:00 (9 PM)
1/11/18
1/15/18
1/17/18
1/20/18
1/22/18

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F 842	Continued From page 68 8/30/17 Physician prescribed Prilosec Capsule Delayed Release 20 milligram Give 1 capsule by mouth two times a day for GERD (Gastro esophageal reflux disease) Omitted Nurse signatures for the following dates at 17:00 (5 PM) 1/11/18 1/15/18 1/20/18 1/22/18 1/17/18 Physician Prescribed Aspiring Tablet Chewable 81 milligrams Give 1 tablet by mouth at bedtime for Coronary Artery Disease prophylaxis Omitted Nurse signatures for the following dates at 21:00 (9 PM) 1/11/18 1/15/18 1/17/18 1/20/18 1/22/18 12/21/17 Physician Prescribed Seroquel Tablet Give 12.5 milligrams by mouth in the evening related to psychotic disorder with delusions due to unknown physiological condition Omitted Nurse signatures for the following dates at 20:00 (8 PM) 1/11/18 1/15/18 1/20/18 1/22/18 The Director of Nursing stated on 2/14/18 at approximately 12:45 PM that due to the trend of dates, she had spoken with the Nurse involved and stated the omissions were a documentation issue and not the Resident missing the medications.	F 842		

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F 842	Continued From page 69	F 842		

The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.

3. Resident #8 was admitted to the Facility on 7/16/12. Diagnoses for Resident #8 included but were not limited to Psychotic Disorder other than Schizophrenia, Left Leg above knee amputation and Asthma.

Resident #8's Annual MDS with an ARD of 2/8/18 coded Resident #8 as having a score of 8 of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating moderate cognitive impairment. The Resident was dependent on staff for bed mobility, transfers, toilet use, personal hygiene, and bathing.

The 4/20/16 Comprehensive Person Centered Care Plan identified the Resident at risk for hypo/hyperglycemia episodes related to non insulin dependent diabetes mellitus. The goal was to be free of signs and symptoms of hypo/hyperglycemia through next review. One intervention included medication as ordered.

Review of Resident #8's Clinical Record January 2018 Medication Administration showed the following Nurse signature omissions:

5/11/16 Physician Prescribed Aricept Tablet 10 milligrams give 10 milligrams by mouth at bedtime for Dementia with behaviors
Omitted Nurse signatures for the following dates for 21:00 (9 PM)
1/11/18

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F 842	Continued From page 70 1/15/18 1/17/18 4/6/17 Physician Prescribed Lantus SoloStar Solution Pen injector 100 Unit/milliter Inject 20 unit subcutaneously at bedtime for Diabetes Mellitus Omitted Nurse signatures for the following 21:00 (9 PM) dates 1/11/18 1/15/18 1/17/18 2/23/16 Physician Prescribed Lipitor Tablet 20 milligarms give 20 milligrams by mouth one time a day for hyperlipidemia Omitted Nurse signatures for the following 18:00 (6 PM) dates 1/11/18 1/15/18 2/22/16 Physician Prescribed Blood Glucose Monitoring two times a day for Diabetes Mellitus Omitted Nurse signatures for the following dates 1/11/18 16:00 (4 PM) 1/14/18 06:00 (6 AM) 1/15/18 16:00 (4 PM) 1/17/18 16:00 (4 PM) 10/12/17 Physician Prescribed Buspirone HCl tablet give 10 milligrams by mouth two times a day for anxiety Omitted Nurse signatures for the following 17:00 (5 PM) dates 1/11/18 1/15/18 2/23/16 Physician Prescribed Ferrous Sulfate tablet 325 milligrams give 325 milligrams by	F 842		

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mouth tow times a day for anemia
Omitted Nurse signatures for the following 18:00 (6 PM) dates
1/11/18
1/15/18

The Resident's pain scale was not documented on Evening Shift on the following dates
1/11/18
1/15/18
1/17/18

The Director of Nursing stated on 2/14/18 at approximately 12:45 PM that due to the trend of dates, she had spoken with the Nurse involved and stated the omissions were a documentation issue and not the Resident missing the medications.

The Facility provided no documentation Policy and Procedure.

The Eighth Edition of Fundamentals of Nursing Potter and Perry 2013 documented the following:

"Documentation is anything written or printed on which you rely as record or proof of patient actions and activities. Documentation in a patient's medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve clinical data, maintain continuity of care, track patient outcomes, and reflect current standards of nursing practice. Information in the patient record provides a detailed account of the level of quality of care delivered to patient. Effective documentation ensures continuity of care, saves time, and minimizes the risk of errors."

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F 842	Continued From page 72 The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings. The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.	F 842		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the Medical Director attended and signed the quarterly Quality Assurance (QA) meetings.	F 868	1. No correction to be made. 2. All residents are at risk for this deficiency and moving forward the Medical Director will attend and sign in at	3/30/18

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F 868	Continued From page 73 The findngs included: On 02/13/18 1:39 PM an interview was conducted with the Administrator regarding the facility's Quality Assessment and Assurance (QAA) program. The quarterly sign in sheets acknowledging committee members attendance were reviewed for 3/19/17, 5/11/17, 8/25/17, and 10/27/17. On the 10/27/17 QAA sign in sheet, it was identified that the Medical Director's signature was not present. There was no other staff identifed as a designee for the Medical Director on the sign in sheet. The facility policy titled, "QAPI" (Quality Assurance and Performance Improvement) effective 11/28/17 documented in part, as follows: 4). The facility will maintain a QAPI committee consisting at a minimum of: b) The Medical Director or his or her designee; 8). A separate "sign-in" sheet will be maintained with the date of the meeting and Committee member name, title, and signature to be provided, as requested, to inspectors or auditors. On 02/13/18 03:50 PM during a pre-exit interview with the Administrator, the Director of Nursing, and the Director of Clinical Services the above information was reviewed. The Administrator was asked about the Medical Director's signature for 10/27/18. The Administrator stated, "I assumed the doctor signed the sheet, he sits next to me. I think he just missed it, he was talking. My expectation is that they (committee members) will all sign". Prior to exit no further information was provided.	F 868	the QAPI meeting. 3. Administrator will check before QAPI meetings begin that each of the required staff including the Administrator, Director of Nursing, Medical Director or his designee, and two other members of the facility staff have signed the QAPI sign in sheet. Administrator will provide education regarding the requirement of attendance and signature for QAPI meetings. 4. An audit will be conducted each QAPI meeting x 3 months to ensure signatures of required personnel are on the sign in sheet. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. March 30, 2018	

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/30/18

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F 880	Continued From page 75 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to maintain an infection prevention and control program to provide safe and sanitary environment and to help prevent the development and transmission of communicable disease and infection for 3 of 56 residents in the survey sample (Residents #7, #105, and #365), and in the facility Dining Room. The facility also failed to maintain an effective infection control system to prevent nosocomial	F 880	1. CPAP for resident # 7 was cleaned. Hand sanitizer was made available immediately during the survey in the dining room for CNA's while assisting residents with eating. Glucometer for resident # 105 was cleaned and UTI's were addressed on antibiotic tracking form. Immediate in-servicing done with nursing department staff on hand washing procedures.	

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F 880	Continued From page 76 infections. 1. The facility staff failed to ensure infection control measures were implemented in Continuous Positive Airway Pressure (CPAP) care for Resident #7. 2. The facility staff failed to ensure infection control measures were implemented between feeding of Residents in the Dining Room. 3. The facility staff failed to maintain an effective Infection Control Program to prevent nosocomial infections (Nosocomial-originating or taking place in a hospital or other health care facility); urinary tract infections (UTI's). 4. The facility staff failed to clean the glucometer after obtaining a blood sugar reading for Resident #105. 5. The facility staff failed to wash her hands after providing incontinent care of stool for resident #365 during wound care. The findings included: 1. Resident #7 was admitted to the facility on 5/8/14. Diagnoses listed for Resident #7 included but are not limited to Asthma, Cerebral Palsy, and Non-Alzheimer's Disease. Resident #7's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/13/17, coded Resident #7 as having short and long term memory problems and was coded a Zero, indicating independent with decisions regarding tasks of daily life.	F 880	2. All residents are at risk for the deficiency. There were no other issues identified. 3. The ADON retrained all nursing staff on standards for cleaning Glucometer on February 9-10, 2018. The DON retrained the Wound Care Nurse on February 8, 2018 regarding cleaning of hands after providing incontinence care and before continuing wound care. The DON and ADON will ensure CNA's are educated on sanitization of resident hands and their own hands while in the dining room. The correction was made on February 6, 2018. ADON or designee will educate licensed nursing staff on causes of UTI's and if clusters are identified, care planning for the residents UTI will be completed. As part of care planning, staff education and interventions will be implemented to prevent the spread of potentially infectious microorganisms that cause similar issue. The ADON or designee will in-service licensed nursing staff on cleaning of the CPAP machine. 4. Unit Managers or designee will audit dining room to ensure hand sanitizer is being utilized by staff while feeding residents bi-weekly x 3 months. Unit Managers will audit CPAP machines weekly x 3 months to ensure cleanliness.	

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F 880	Continued From page 77 Resident #7 was coded as completely dependent on two staff for bed mobility and transfers. Resident #7 was dependent on 1 staff for toilet use, personal hygiene and bathing. The Comprehensive Person Centered Care Plan revised on 7/7/16 identified the resident focus area "Altered Cardiac/Resp (Respiratory). Functioning r/t (related to) ...asthma." The goal was to have no cardiac complications. One intervention included CPAP as ordered at HS (hour of sleep) and Oxygen therapy as ordered. The Comprehensive Person Centered Care Plan did not address the fact that Resident #7 was changing his personal Nebulizer Unit's filter. Resident #7's Physician Orders included: 2/12/18 Cleanse CPAP mask with soap and water every week and as needed. Air dry prior to use. Every day shift every Saturday for CPAP care. 2/12/18 Cleanse CPAP tubing with soap and water every week and as needed. Air dry prior to use ever day shift every Saturday for CPAP care 2/22/16 CPAP at bedtime for sleep apnea CPAP to be worn every night at bedtime Record Review of Resident #7's Clinical Treatment Administration Record (TAR) showed no signature of the nurse assessing that the Resident's CPAP was on for the following dates: 1/4/18 1/11/18 1/12/18 1/15/18 1/17/18	F 880	Unit Managers will audit glucometers bi-weekly x 3 months to ensure proper cleaning by nursing staff. DON or designee will audit antibiotic tracking forms weekly x 3 months to ensure UTI's are identified. The results of audits will be forwarded to the facility QAPI committed for further review and recommendations. 5. March 30, 2018	

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F 880	Continued From page 78 1/20/18 1/22/18 1/29/18 On 2/6/18 during the initial tour at approximately 10:30 AM, Resident #7 stated his CPAP mask hadn't been cleaned since he had been admitted to the Facility. The Resident stated that he changes his own nebulizer filters. There were no dates observed on the CPAP unit or the Nebulizer unit. The CPAP mask was observed and it was sticky to touch. On 2/14/18 at approximately 9:45 AM, the Resident reported that someone had cleaned his CPAP masks. An interview with LPN #6 was conducted on 2/8/18 at approximately 4:54 PM and she stated when asked how she would clean and care for the Resident's CPAP and nebulizer. LPN #6 stated that cleaning is generally done on night shift 11 PM to 7 AM and she stated that she has worked that shift previously. LPN #6 stated that the masks are cleaned weekly with soap and water and after cleaning the masks are to be placed in a plastic bag with a date. The LPN stated that the mask could be cleaned as needed at any time. When asked where the filter was on the nebulizer unit, LPN #6 stated, "I didn't know the nebulizer had a filter." An interview with the Director of Nursing #2 was conducted on 2/13/18 at approximately 3:45 PM. The Director of Nursing stated that she was aware the facility had issues with the CPAP devices related to the multiple gaps on the Treatment Administrator Record. In addition, the Director of Nursing stated the distilled water	F 880		

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should have an open date on it.

The Facility provided undated guidance for "Cleaning Your Mask at Home" and it documented the following:

"Wash your mask excluding the Headgear Assembly in soap dissolved in lukewarm water. Do not soak for more than 10 minutes."
"You should clean the air tubing weekly as described."
"1. Wash the air tubing in warm water using mild detergent. Do not wash in a dishwasher or washing machine."
"2. Rinse the air tubing thoroughly and allow to dry, out of direct sunlight and/or heat."

The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.

2. On 2/6/18 at approximately 12:39 PM an observation of a CNA #5 in the Main Dining Room sitting between two residents and feeding them at the same time. CNA #5 using her right hand would give one resident a spoon or fork full of food and then turn and give the other resident a spoon of food. CNA #5 was observed assisting one of the residents to blow his nose, then she placed the soiled napkin on the table and turned and fed the other resident a fork full of food. At no time during the feeding of the two residents did CNA #5 wash her hands.

On 2/6/18 at approximately 12:45 PM CNA #5 was asked about feeding two residents and not washing her hands in between. Initially, CNA #5

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didn't think she had done anything wrong until she was asked what she should have done after assisting the resident to blow his nose by holding a napkin to his nose. At that time CNA #5 stated, "I should have washed my hands."

The Corporate Registered Nurse #3 stated on 2/7/18 at approximately 9:55 AM, "Yes she should have washed her hands between feeding two residents." RN #3 stated that the facility would be providing hand sanitizer to be used in the dining room.

The Center for Disease Control documented the following:
"Practicing hand hygiene is a simple yet effective way to prevent infections. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics and are becoming difficult, if not impossible, to treat. On average, healthcare providers clean their hands less than half of the times they should. On any given day, about one in 25 hospital patients has at least one healthcare-associated infection."

The Facility was updated during a pre-exit interview on 2/13/18 at approximately 3:48 PM and again during the exit interview on 2/14/18 at approximately 2:00 PM. The facility did not present any further information about the findings.
3. On 2/9/18 at 4:31 pm, an interview was conducted with the Assistant Director of Nursing (ADON) who was responsible for the Infection Control Program Surveillance (data collection). A review of the December 2017 infection surveillance log evidenced there were 7 Urinary Tract Infections (UTIs); 2 residents were admitted from the hospital with a UTI, and 5 UTIs were nosocomial to include a cluster of 4 urinary tract

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infections on the 400 hallway on unit two. Four residents in close proximity of each other were identified as having a UTI. The organisms were identified as E.Coli, Proteus Mirabilis and gram negative rods. All of these organisms are found in the gastrointestinal system and can be transmitted to the urinary tract during improper incontinence care.

The ADON was asked what actions were taken as a result of identification of the UTI cluster. She stated she informed the Director of Nursing (DON). The ADON was asked what was the purpose of analysis of surveillance data. She stated "to find trends, identify weaknesses and address them...such as clusters." When asked when a cluster is identified what would be the facility's action, she stated, "Education to lower the risk in the future." When asked if any inservice education was provided to the direct care staff to prevent further facility acquired (Nosocomial) UTI's, she stated no. She stated the DON had identified the certified nurse aide (CNA) responsible for not providing appropriate incontinent care, and that CNA was no longer an employee.

The DON was asked to provide documentation on the investigation of the cluster. She was not able to provide any. She stated the CNA was identified as working the night shift and was found to not provide timely incontinent care. She stated she had "deducted" that this one particular CNA was the cause of the cluster. When asked about education to the other staff to prevent further UTI infections, she stated, "We dropped the ball".

The facility was not able to provide documentation of follow-up activity in response to

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the identified cluster.

The bacterium Escherichia coli (E.coli), which causes the majority of urinary tract infection, will appear as pink (gram negative) rods under the microscope. The vast majority of urinary tract infections are caused by the bacterium E.coli usually found in the digestive system. www.nhi.gov (National Health Institute)

Proteus Mirabilis is part of the normal flora of the human gastrointestinal tract. When this organism, however enters the urinary tract, wounds, or the lungs it can become pathogenic. (www.nhi.gov)
4. Resident #105 was admitted originally admitted to the facility on 08/01/17. Diagnosis for Resident #105 included but are not limited to Diabetes Type II.

Resident #105 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/18 coded the Brief Interview for Mental Status (BIMS) score an 11 out of a possible 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #105 requiring total dependence of two with transfers, total dependence of one with bed mobility, dressing, eating and toilet use and extensive assistance of one with personal hygiene and bathing of Activities of Daily Living care.

On 02/09/18 at approximately 5:23 p.m., during the medication pass and pour observation, License Practical Nurse (LPN) #4 removed an alcohol pad, 2 x 2 gauze, a lancet, a test strip and glucometer from a plastic bag from the medication cart; the plastic bag also contain extra lancets. LPN #4 went into the resident's room

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then proceeded to clean the resident's finger with an alcohol pad, pricked his finger with lancet, inserted test strip into the glucometer to obtain his blood sugar. After obtaining blood for blood sugar, LPN #4 returned to the medication cart, placed the glucometer back into the white plastic bag without disinfecting the glucometer. The surveyor asked if the glucometer machine should be cleaned after use, the LPN stated, "Even though each resident has its own machine they still need to be cleaned after use."

On 2/13/18 at approximately 10:25 a.m., an interview was conducted with the Director of Nursing (DON) who stated, "The nurse should have cleaned the glucometer machine after use then place in plastic bag."

The facility administration was informed of the finding during a briefing on 2/13/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.

The facility's Policy: (AL Glucometer Policy) Section (Infection Control) Revision Date: May 2016

Policy: All nurses and Med Techs will be trained on proper use and cleansing of the glucometers and that each resident requiring blood glucose testing will have there own glucometer.

Procedure:
B. The Med Tech or nurse will clean the resident's glucometer after each use. (Glucometers are not to be shared.)

5. Resident #365 was admitted to the facility on 02/05/18. Diagnosis for Resident #365 included

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F 880	Continued From page 84 but not limited to *Methicillin Resistant Staphylococcus Aureus Infection (MRSA) and *Unstageable sacral pressure ulcer wound. *MRSA is a bacterium that causes infections in different parts of the body. It is tougher to treat than most strains of staphylococcus aureus or staph - because it is resistant to some commonly used antibiotics. *Pressure Ulcer is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) . *Pressure Injury - Unstageable (Obscured full-thickness skin and tissue loss) Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .	F 880		

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The admission evaluation assessment dated 02/05/18 coded Resident #365 being alert and oriented x 3. In addition, the admission evaluation assessment coded requiring assistance of two with bed mobility, toileting, and transfers and assistance of one with bathing, dressing and eating.

A Braden Risk Assessment Report was completed on 2/5/18; resident scored eleven (11) indicating very high risk for development of pressure ulcers. Mobility is completely immobile; does not make even slight changes in body or extremity position without assistance.

According to the Medication Administration Record (MAR) for February 05, 2018, resident was admitted to the facility on Vibramycin 100 mg 1 capsule by mouth every 12 hours and Cipro tablet 500 mg 1 tablet by mouth every 12 hours for MRSA in wounds x 2 days.

According to admission, evaluation on 2/5/18 under wound overview indicated the following: Unstageable pressure ulcer to the sacrum measuring 7.5 cm x 6.5 cm, moderate amount of serosanguineous drainage with wound bed appearance being black in color with yellow slough, no odor present.

The review of Resident #365 care plan documented Resident with actual skin breakdown to the sacrum. The goal: the sacrum will show improvement and be free of signs and symptoms of infection. Some of the interventions to manage goal included but not limited to administer treatment as ordered, assess and document the status of the area (healing vs declining), Redistribution mattress and turn and reposition as

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needed.

The current treatment as 02/06/18 is to clean sacral wound with wound cleanser, apply betadine soaked gauze and cover with a foam dressing daily and as needed.

On 2/8/18 at approximately 11:30 a.m., Resident #365 was lying in bed, positioned on his left side, lying on an alternating low air loss pressure mattress. A Foley catheter was at the bedside draining clear yellow urine; the catheter anchored in place. Prior to starting wound care to the resident, the wound nurse and CNA # 2 washed their hands. The wound nurse repositioned the resident on his left side with the assistance of CNA #2. The wound nurse removed her gloves, used hand sanitizer and then donned a new pair of gloves. She then removed the foam dressing that covered the sacral wound. The nurse then placed the soiled dressing inside a red biohazard bag. The sacral wound bed was noted with eschar and yellow slough; a moderate amount of serosanquineoous drainage ran down from the sacral wound; no odor was noted.

The LPN removed her gloves, used hand sanitizer and donned another set of gloves. She then proceeded to cleansed the sacral wound in a circular motion using wound cleanser, removed the gloves, and used hand sanitizer. The Resident started having bowel movement; the nurse used 4 x 4 gauzes to clean bowel movement two times, then placed in 4 x 4 gauze in a red bag, removed the gloves, used hand sanitizer, donned a pair of gloves, then proceeded to complete wound care. The nurse painted the sacral wound with Betadine in a circular motion, removed the gloves, applied hand

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sanitizer, applied skin prep around the outer edges of the sacral wound, placed Betadine gauze cover with the sacral wound, then covered with a foam dressing, removed the gloves, and washed hands for 32 seconds.

An interview was conducted with the wound nurse on 2/12/18 at approximately 11:45 a.m., who stated, "I thought I washed my hands after I cleaned resident after having a bowel moved but if I didn't wash my hands; I should have.

The facility administration was informed of the findings during a briefing on 2/14/18 at approximately 3:30 p.m. The corporate nurse stated the nurse should have washed her hands after she finished providing incontinent care of stool before finishing wound care.

The facility's policy: Hand Washing (Infection Control)
Policy: Handwashing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing.

The facility's policy: Pressure Ulcer Policy (Revision: 1/18/17)
Policy:
It is the policy of saber Health Care based on the comprehensive assessment of a resident; the facility must ensure that -
-A resident with pressure ulcers receives necessary treatment services, consistent with professional standards of practice, to promote healing, prevent infections and prevent new ulcers from developing.
The facility's skill steps for clean dressing application.

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F 880	Continued From page 88 -Explain the reason and procedure to the resident. -Wash your hand and pull the curtain. -Put on gloves. -Remove the soiled dressing. Discard in plastic bag or according to facility policy. Avoid crossing over clean supplies with soiled items. -Cleanse wound with the solution ordered. Always clean the area from the center out or from the cleanest to least clean area. -Remove and discard gloves. Wash bandage scissors with soap and water if used during soiled part of procedure. Wash hands. Apply new gloves. According to The Long-Term Care Pocket Guide for Infection Control: A Resource for Frontline Staff (2008), Section 2 Hand Hygiene, "Wash hands before and after all client or body fluid contact. Immediately wash hands and other skin surfaces that are contaminated with blood or bodily fluid. When wearing gloves, wash hands as soon as the gloves are removed. Germicidal handrubs are recommended only when you can't wash."	F 880		